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ABSTRACT

The National Institute on Drug Abuse (NIDA) has developed training and technical assistance services to train indigenous outreach workers hired by NIDA's national Acquired Immune Deficiency Syndrome (AIDS) outreach demonstration research projects. The NIDA community outreach demonstration research projects for AIDS are the first large-scale, nationwide AIDS outreach efforts targeted specifically to intravenous drug users and their sexual partners. One of the first activities of this training and technical assistance effort involved convening two program development meetings (held in 1989 in Rockville, Maryland and Millbrae, California) to assess training needs and assist in the development of appropriate modules for use in the field. This summary of information presented by the projects participating in these meetings was developed to disseminate the information from the meetings. It presents issues, technical approaches, and alternative action plans for a variety of AIDS outreach project operations in the hope that the dissemination of this information will allow all AIDS community outreach and demonstration research projects to benefit from the experience of their colleagues. The summary is intended to encourage ongoing communication and consultation among outreach projects across the country. The report's six chapters provide an introduction to outreach work and describe, respectively, the background of the NIDA AIDS Community Outreach and Demonstration Research Projects, the hiring of outreach workers, outreach strategies, staff operations and supervision, and outreach workers' training. The AIDS Policy and Procedure Problem Resolution Model, the Workshop Problem Analysis and Resolution Instrument, and the NIDA Directory of Outreach and Demonstration Research Projects by state and city with names of contact persons are appended. (NB)

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U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Public Health Service
Alcohol, Drug Abuse, and Mental Health Administration

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Program Development for Community AIDS Outreach

Clinical Report Series

Editor:
Rebecca S. Ashery, D.S.W.

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Public Health Service
Alcohol, Drug Abuse, Mental Health Administration

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FOREWORD

The National Institute on Drug Abuse (NIDA) has developed training and technical assistance services to train indigenous outreach workers hired by NIDA's national AIDS outreach demonstration research projects. The NIDA community outreach demonstration research projects for acquired immunodeficiency syndrome (AIDS) are the first large-scale, nationwide AIDS outreach efforts targeted specifically to intravenous (IV) drug users and their sexual partners. Because the projects are the first of their kind, there is no existing body of knowledge concerning methods and strategies for AIDS outreach.

One of the first activities of this training and technical assistance effort involved convening two program development meetings to assess training needs and assist in the development of appropriate modules for use in the field. The meetings were held in February 1989 in Rockville, MD, and Millbrae, CA. Before the meetings, a survey was conducted to ascertain project training needs. Staff from each participating project had the opportunity to identify and discuss training issues. Their response showed that the most critical areas in need of assistance were (1) outreach strategies and (2) hiring processes, followed closely by (3) supervisory and training needs. This initial assessment provided the three major topic areas for the meetings.

Participants at the meetings assessed their current level of policy and procedural development in each of the three topic areas by using Appendix A, AIDS Outreach Project Policy and Procedure Problem Resolution Model. The model was designed not as a checklist but to facilitate the identifying of problems and resolution areas in outreach program development.

After the project staff completed the problem resolution model, a working group was formed for each of the three topic areas to discuss specific problems and relevant solutions for individual projects. Appendix B presents the Workshop Problem Analysis and Resolution Instrument. Participants in each of the three topic areas used this instrument to present alternative approaches to program development, special issues encountered in the field, and examples of approaches to developing indigenous community outreach programs.

To disseminate this information, NIDA has compiled this summary of information presented by the participating projects. The program development meetings have been extremely helpful to the national effort and have provided a clear assessment of the issues involved in developing and managing community outreach programs.

This summary presents issues, technical approaches, and alternative action plans for a variety of AIDS outreach project operations. All participating projects have assisted

NIDA in this effort by documenting their approaches and contributing papers and presentations. NIDA is disseminating this information to allow all AIDS community outreach and demonstration research projects to benefit from the experience of their colleagues.

This summary is intended to encourage ongoing communication and consultation among outreach projects across the country. Appendix C, NIDA Directory of Community Outreach and Demonstration Research Projects, includes a list of projects by State and city as well as names of contact persons.

1. INTRODUCTION

Outreach activities originated in response to some of the social ills of the industrial revolution. It was not until the 1960s, however, that the concept of "outreach worker" emerged as a helping profession that could supplement the efforts of institutionalized systems of assistance. This concept has developed through a succession of helping strategies and now is considered one of the most viable health education techniques that can be applied to the AIDS epidemic.

The Origin of Outreach

Although individuals have long volunteered their services to help their neighbors, the first time laypeople were organized as an integral part of a health program was in Philadelphia in the late 19th century. At that time, tuberculosis was one of the most serious health problems in the country. Authorities realized that both the government and the citizenry had to be involved in fighting the disease. Although it was agreed that only government had the resources to bring the disease under control, laypeople could play a vital role in rallying public support and informing both the populace and government officials about the problem. Thus, in 1892, the Anti-Tuberculosis Society of Philadelphia was formed. Although these laypeople were not paid for their work, their efforts eventually led to the organization of 50 State associations with approximately 32,000 local affiliates. The Anti-Tuberculosis Society was the forerunner of today's outreach programs; it is now known as the American Lung Association.

Another key element that laypeople contributed to the current concept of outreach is education. Although laypeople perform many functions in health work, education is their most important function. Because laypeople achieved success as educators in volunteer health programs, it was only a matter of time before official health agencies decided to use them in government health programs. In 1914, the New York City Health Department was the first government agency to create a bureau of health education; the same year, the New York State Health Department was established. Other city health departments soon followed this lead, particularly the Detroit Department of Health, whose division of health education pioneered the organization of neighborhood health groups, clubs, and guilds that intimately and effectively involved the targets of the health education efforts, especially the socioeconomically disadvantaged. Thus, the provision of health education by trained laypeople gradually became accepted as an integral and viable part of the programs offered by official health agencies.

Although laypeople provided health education services during the early part of the century, it took another national crisis, the War on Poverty, in the 1960s, to show that laypeople could help communities solve their problems. Laypeople effectively demonstrated that they could gain the understanding and support of community members

and provide training, education, and referral services; thus, the current concept of today's outreach worker was formed.

The New Professional

Outreach workers (also known as health education aides, community health workers, home health guides, mobile teachers, and health coordinators) are a new type of professional whose knowledge and abilities are acquired in the school of hard knocks. This new breed of health educator comes to the job already possessing the necessary skills and abilities for successful outreach work. The life experiences and the skills that outreach workers have developed to deal with their own problems make them uniquely qualified to help community residents help themselves. At the same time, these workers can gain support from the community to help it meet its objectives.

Outreach workers are no longer considered just concerned laypeople; with their expertise, they have proven themselves to be professionals in the field of "involved education." Skilled in the art of grassroots communication, they have demonstrated that they are the key to building and maintaining the community support that is vital to program success.

Outreach workers receive intensive training in the problems addressed by their agencies. They learn communication skills, motivational techniques, and health education and disease prevention strategies, and they become well versed in the full range of public and private services that are locally available. The natural skills of indigenous community health workers are essential to successful outreach efforts. Once hired, these workers learn to enhance their skills through training in order to

- learn to accept appropriate administrative authority;
- understand the importance of confidentiality;
- overcome any feelings of worthlessness or frustration resulting from previous life experiences;
- identify community problems;
- recognize potential community leaders;
- bring people together into a cohesive group;
- link groups together;
- provide health education messages;

- learn to be nonjudgmental; and
- guide residents in identifying meaningful goals and selecting methods to achieve those goals.

In most areas, outreach workers are recruited directly from the neighborhoods where programs are concentrating most of their activities and efforts. The main role of outreach workers has been to serve as the link between the programs and the communities they serve, and their primary task has been to gain community acceptance and encourage involvement in these programs. This approach requires that the intervention be designed and implemented with a thorough knowledge of particular cultures and ethnographically distinct populations. Communication with such groups requires an understanding of various cultural aspects, such as street behavior and street language.

Often, the target populations do not trust outside intervention because of a long history of punitive approaches intended to control crime. In addition, communication between the street population and persons from mainstream American society has been limited and antagonistic.

In response to these reactions, the concept of the indigenous outreach worker has evolved into the most effective way to communicate and transfer intervention methods within the street environment. Some outreach workers who are ex-addicts are from the same ethnographic, cultural, and street environment as the target population; therefore, they are best equipped to locate and communicate with this population.

The outreach activities of current programs involving drug users are based on a thorough understanding of the ethnography and cultural characteristics of specific target groups and carefully defined geographic regions. As the complexity of cultural patterns and the diversity of such regions have become better understood, an ethnographic concept of drug use, prevention, and intervention has developed. This concept considers the full social and cultural environment surrounding drug use within a particular community in order to develop interventions that are appropriate to that environment.

When outreach projects introduce government initiatives to communities, the projects should include bartering tools (e.g., resources, assistance with the most pressing priorities, telephone numbers that bring immediate response, or an individual with whom clients can relate) so that community members feel there is personal involvement rather than government anonymity. Armed with these bartering tools, plus a natural commitment and empathy, outreach workers can implement community programs, which are accepted because they have established credibility.

Concentrated use of community health outreach workers in a specified prevention program is the most effective means of implementing the program for the people who

need it. Because outreach workers make contacts on a one-to-one basis, there is interchange and feedback. This personal contact reaches a variety of people, such as IV drug users, prostitutes, alcoholics, housewives, and children. In addition, this type of intervention reaches individuals who do not participate in normal community activities.

Since the first pilot outreach program was implemented in an urban area in 1966, outreach workers have made a tremendous contribution to the health, welfare, and well-being of tens of thousands of community residents across the country, especially in those areas where Federal grants have supported prevention programs. During the late 1970s and 1980s, funding for outreach activities was greatly decreased. Because of the national AIDS crisis, however, community health outreach workers once again have gained prominence as the most effective means to provide health education, especially among IV drug users. As a result, NIDA has implemented the AIDS community outreach and demonstration research projects. Outreach workers are viewed as professionals in involved education; they also can be effective for any program that concerns the mental, physical, and social well-being of community residents.

2. BACKGROUND OF NIDA AIDS COMMUNITY OUTREACH DEMONSTRATION RESEARCH PROJECTS

In 1987, NIDA began to develop community outreach demonstration research initiatives to address the problem of AIDS and drug abuse. At that time, 67 percent of AIDS cases were reported among gay and bisexual men. From September 1987 to January 1991, 59 percent of AIDS cases were reported among gay/bisexual men, and 32 percent of AIDS cases were IV drug use related.¹ More than one-quarter of a million IV drug users were estimated to be seropositive and likely to infect others through needle sharing, sexual contact, or pregnancy.

NIDA's national AIDS outreach demonstration research projects were initiated in September 1987 with six comprehensive community grantees and five AIDS-targeted outreach model contracts. As of January 1989, NIDA had funded 63 sites for its AIDS community outreach and demonstration research projects across the Nation. These projects implement and assess a broad diversity of outreach methods and intervention strategies with the objective of identifying the most effective approaches for specific target populations and geographic locales. The projects target two major high-risk populations: (1) the estimated six out of seven IV drug users who are not in treatment and are therefore less likely to receive AIDS prevention education; and (2) the sexual partners of IV drug users (who represent a significant percentage of the heterosexual AIDS cases).

Although each project has a unique approach to the community it serves, models for outreach to the following eight target populations are employed for the NIDA projects:

- sexual partners of IV drug users and prostitutes;
- drug users in emergency rooms and detoxification units;
- IV drug users' indigenous leaders;
- methadone maintenance contacts and clients;
- therapeutic community contacts and clients;
- pregnant women and their children;

¹ *HIV/AIDS Surveillance*, issued February 1991, USDHHS, PHS, CDC. Center for Infectious Diseases, Division of HIV/AIDS.

- arrested drug users; and
- drug users in public housing projects.

Models of AIDS Outreach Programs

The NIDA projects may implement one or any number of the targeted population models or incorporate all eight target populations as well as other models. The specific strategy for reaching and educating the targeted population depends on the unique characteristics of the community. Some of the projects' major objectives are as follows:

- to assess HIV seropositivity rates among target populations;
- to determine the nature and extent of risk-taking behaviors (i.e., IV drug use, needle sharing, and sexual behavior);
- to communicate information about AIDS and risk reduction;
- to use various intervention models to reduce risk-taking behaviors;
- to refer IV drug users into treatment and other community services; and
- to evaluate the outcomes on both the local and the national levels.

Program Objectives

In all instances, the projects use trained indigenous outreach workers to identify, reach, and communicate with IV drug users who are not in treatment and their sexual partners, as well as drug-using prostitutes. In addition, most projects use ethnographers to assess patterns of drug use and characteristics of the drug-using population. Some projects also may target a subpopulation (e.g., persons admitted to hospital emergency rooms or detoxification units, prison inmates, prostitutes, or sexual partners of IV drug users). The projects collect data on the target population and on behavioral changes to develop effective intervention models. Doing so requires community participation in the planning and development of the intervention model as well as continued participation in the intervention sessions, followup identification, and assessment of behavioral changes.

Outreach Worker Responsibilities

The primary responsibilities of community health outreach workers are as follows:

- to make personal contacts with community residents and organizations;
- to contact IV drug users and their sexual partners as well as prostitutes;

- to distribute preventive materials (e.g., condoms, bleach for sterilizing works);
- to communicate AIDS risk reduction messages;
- to facilitate behavioral changes; and
- to refer contacts for interview screening and risk reduction counseling as well as AIDS antibody testing and services, where appropriate.

Project Evaluation

The projects will be evaluated on the basis of both process and outcome data generated in part by an AIDS initial assessment questionnaire and an AIDS followup assessment questionnaire. Behavioral changes over time and the efficacy of the interventions among different population subgroups will be assessed on the local project level as well as on the national level across sites by means of these detailed questionnaires.

Training and Technical Assistance

NIDA has developed both training and technical assistance services for the indigenous outreach workers hired by the projects. One of the first activities of this training and technical assistance effort involved convening two program development meetings to assess training needs and assist in developing appropriate modules for use in the field. The meeting agenda included hiring practices, outreach strategies, and staff operations and supervision as follows.

Hiring Practices

The following steps were suggested for hiring outreach workers:

- determining recruitment strategies;
- defining employee qualifications;
- developing job descriptions;
- developing interviewing and hiring processes;
- determining desired staff composition;
- documenting employment procedures and expectations;

- developing sound benefits packages; and
- establishing appropriate work scheduling.

Outreach Strategies

The following outreach strategies were recommended:

- determining appropriate application of ethnographic data;
- identifying and labeling key outreach skills;
- developing staff communication skills;
- developing rapport on the street both with special populations and with law enforcement agencies;
- defining and managing the quality of prevention messages;
- implementing strategies that are sensitive to different cultural needs;
- networking with adjunct services and community-based organizations;
- identifying resources and developing skills; and
- recruiting interview subjects.

Staff Operations and Supervision

The following practices were suggested:

- developing job descriptions for supervisors;
- defining models and techniques for supervision;
- monitoring staff accountability;
- enforcing policies and procedures;
- evaluating employee performance;
- bridging research and outreach service functions;
- developing and implementing staff training;

- identifying resources for staff development; and
- teaching time management, writing, organization, and other job skills.

Participants presented alternative approaches to program development, special issues encountered in the field, and examples of approaches to developing indigenous community outreach programs. Some programs were in the early stages of problem definition, whereas others had implemented highly successful and innovative approaches. In general, the meetings and workshops elicited a wealth of information about technical approaches, special populations, model policies and procedures, and obstacles to avoid or overcome.

3. HIRING OUTREACH WORKERS

Issues

Hiring community health outreach workers poses unusual challenges. Outreach workers are seldom integrated into the mainstream of employment opportunities. In many cases, the skills required of outreach workers cannot be learned in traditional education or training programs. The greatest strength of outreach workers is that they are indigenous to a particular community; however, conventional opportunities for employment may be rare in that community. Therefore, many highly desirable candidates for outreach work have never held conventional jobs.

Many of the skills required for outreach work are acquired in the streets and in the drug subculture. For example, a former drug dealer may have learned invaluable outreach skills in the course of a criminal career. To be a successful drug dealer, the person had to display charisma, market and control the quality of the product, be respected and dependable, be knowledgeable about self-defense, be accepted in an underground protection network, have existing personal relationships with individual members of the community, and have personality traits that could be described as levelheaded, ingenious, and daring. Despite the unconventional origins of all these qualities, they may be highly useful for outreach work. The challenge for outreach projects is to identify indigenous persons who have such assets and help them to transfer these skills to outreach and community service. For some outreach workers, these jobs may be their first legitimate jobs requiring a 40-hour workweek.

Many issues distinguish the hiring of outreach workers from hiring for conventional employment. The very nature of indigenous community outreach means that candidates must be familiar with street behaviors, street language, drug use patterns, and a wide range of ethnographic concerns in their own community. Community outreach workers should be

- fluent in street language or even street language in a foreign tongue, such as Spanish, or a dialect such as Haitian French;
- nonjudgmental about drug use or sexual practices and without preconceptions;
- capable of establishing trusting relationships with drug users on the street;
- credible in the community;
- successfully pursuing a program of recovery or aftercare (if applicable);

- connected with networks of community contacts;
- of a noncontentious personality type;
- positive toward authority figures such as the police;
- able to function as a member of a diverse team;
- willing to accept training; and
- able to serve as a role model for recovering persons within the street culture.

It is particularly important that outreach workers be self-motivated and have the skills required to make continuous contacts with drug users and dealers without endangering their own recovery or compromising their own or their co-workers' credibility in the community.

In addition to the positive qualities that have been listed, outreach workers need to be capable of overcoming a number of obstacles. Outreach candidates are often less than fully literate and may require training in basic reading and writing skills. Candidates frequently are unfamiliar with conventional living skills, such as personal budgeting, banking, acquiring a driver's license, or merely showing up for work consistently. In addition, returning to the street could trigger a relapse for outreach workers in recovery. Moreover, outreach workers must be able to work in a violent and dangerous environment without letting the stress of that condition become unmanageable.

In all cases, outreach workers who are in recovery are required to maintain an ongoing program of treatment. Ideally, candidates should view themselves as workers who are building a positive future and developing a career within the mainstream. The success of indigenous outreach workers provides hope to other members of the community and inspires them to take positive actions to ensure their own well-being.

In response to these issues, meeting participants identified some useful strategies to assist other projects in the hiring process. The rest of this chapter briefly summarizes possible approaches for organizing and implementing a hiring and personnel system for the NIDA AIDS community outreach and demonstration research projects.

Laying Groundwork

Representatives of the participating projects invariably stressed the need to prepare for the hiring process. This process should be the same for any employee whom the project hires, and the qualifications needed to perform the work should be clear. First, project staff must know and understand the realities of the target community.

Doing so generally requires firsthand contact with local drug users, prostitutes, and the sexual partners of drug users. Participants suggested that the person responsible for hiring spend considerable time as an observer on the streets and work with an ethnographer to understand the drug use patterns and sociology of the target community. Essentially, outreach workers should know exactly what is going on in the streets, who the target populations are, and what concerns exist within the community. Early exposure within the target community has numerous benefits:

- It allows the project to determine the mix of ethnic, racial, language, or gender groups that will be required of the outreach staff.
- It provides an opportunity to inform community members about the project's goals and explain why the project is beneficial and nonthreatening.
- It often allows the person responsible for hiring to form linkages with an informal network of contacts within the drug culture who can identify candidates for outreach work.
- It allows the project to create liaisons with local community organizations--such as treatment programs, churches, schools, law enforcement agencies, and other health and service providers--that will be useful for referrals. Such liaisons are also useful for creating system linkages (the process of having organizations refer participants to the outreach project). Such groups often can make useful recommendations about recruitment strategies.
- It allows the project to develop a positive identity and to foster tentative acceptance of its activities before sending outreach workers into potentially dangerous situations.

Defining Employee Qualifications

Many of the unique qualifications of outreach workers involve their community backgrounds and personality traits in addition to specific job skills. Participants stressed repeatedly that certain job skills can be taught after employment (e.g., basic knowledge of AIDS and prevention). On the other hand, many of the most crucial qualities are those that outreach workers must bring to the project from their direct experience in the community.

Participants generally agreed that different types of outreach workers are essential for a balanced, well-targeted outreach team. The composition of the outreach team should match the composition of the target community--for example, Hispanic outreach workers for Hispanic communities, black workers for black communities, and female workers for women's programs. However, participants emphasized that each worker

should be chosen on an individual basis according to specific criteria based on the project's target populations and particular locale. For example, drug use patterns in Harlem are not the same as those in the Bronx, and each community requires an outreach worker from its own specific locale; or the drug-using population of a community may be mostly older or both young and old, which affects the hiring process. Participants also noted the importance of working in pairs, which influences who is hired. An important consideration regarding Hispanic outreach workers is that they cannot be distinguished by surname or language skills alone. The Latino/Hispanic communities vary greatly in their subcultures, depending on where they are located. The social and language patterns of different subgroups (e.g., Puerto Ricans, Cubans, Mexicans) are quite different, and each group requires an outreach worker from that particular community. In many instances, projects will need to develop a team of outreach workers with different backgrounds.

Thus, the first step in hiring is to define potential employee qualifications based on the unique nature of the target community, its needs, and the preferred mix of backgrounds that will form a well-balanced outreach team. In general, the following personality and attitude qualifications are required of all outreach workers:

- participation in a program of recovery (if applicable), plus a sufficient length of time in recovery or (for methadone users) 1 year of clean urine profiles;
- nonjudgmental attitude;
- knowledge of street and drug behaviors and language;
- self-motivation;
- good judgment, common sense, and logic;
- credibility within the community;
- trustworthiness;
- courage;
- compassion;
- creativity;
- openmindedness;
- acceptance of authority;

- willingness to work for a positive future;
- good communication skills;
- ability to listen, understand street language, and interpret body language;
- compatibility with other members of the project team;
- skills that complement those of other project staff;
- sense of humor;
- willingness to accept training and adhere to project procedures;
- good observational skills; and
- a predetermined level of literacy.

In addition, participants generally agreed that the following characteristics should be immediate disqualifiers:

- inadequate history of recovery;
- judgmental or inappropriate attitudes concerning sexual practices, drug use, or other social values;
- dishonesty or inability to be open regarding one's own life experiences;
- hostility or contentious behavior;
- current drug use;
- inability to demonstrate a knowledge of street environment;
- willingness to break confidence or "snitch";
- poor references;
- grandiosity;
- aggressive or abrasive behavior;
- tendency to blame failures on other people;

- incompatibility with other project staff;
- evidence of denial behaviors that distort the reality of a problem or addictive behavior;
- hostility toward authority, such as police or supervisors;
- evidence of mental and emotional illness or instability;
- inability to adapt to job requirements (e.g., working hours, required reporting); and
- propensity to develop codependent relations, in which the worker becomes overinvolved in a client's problems.

Participants expressed widely differing opinions concerning the requisite length of time in drug abuse recovery programs, when applicable. The suggested length of recovery periods ranged from 1 to 15 years, although the majority considered 2 years sufficient. The individual's personal plan of recovery and understanding of addiction also were considered important. Some projects use outreach workers who are enrolled in methadone maintenance programs, but others consider methadone use to be an automatic disqualifier. Among those projects using workers in methadone programs, participants discussed the need for a clear urine profile for at least 1 year before employment as well as a specific requirement for methadone maintenance levels. One project had established a cutoff point of 40 milligrams of methadone, but no consensus was reached on this point.

This controversy existed concerning methadone maintenance because some people view it as an addictive behavior and because other addictive drugs, such as cocaine and crack, are unaffected by methadone as a treatment option. In addition, there was concern over recidivism among persons using methadone. Participants agreed that those hiring outreach workers should assess recovery requirements on an individual basis, and they should trust their instinctive reactions, intuition, and sense of rapport with the candidate.

Developing Job and Recruitment Descriptions

Beyond attitude and personality qualifications, participants stressed the need to develop a specific job and recruitment description for each outreach position. The recruitment description should cover the basic duties and responsibilities and background qualifications. The job description should describe the duties and responsibilities in more detail. This description should specify the street or community and ethnographic knowledge required as well as the specific activities for which the worker will be responsible. These activities should be quantifiable and recordable, such as the number

of contacts to be made and screened, the number of contacts to be referred for research interviews, the number of project materials distributed, the procedures for reporting activities, and the objective task descriptions. The job description also should define the target population and the goals and objectives of the project. It was generally agreed that attitude and behavioral qualifications should be limited in job descriptions for outreach work. These matters, however, must be judged subjectively and are not amenable to consistent and unbiased interpretations.

As a second step, participants suggested that individual job descriptions and recruitment descriptions should be developed for particular kinds of outreach activities. For instance, one description may be necessary for outreach to sexual partners of IV drug users and prostitutes, another for outreach to emergency rooms, and another for outreach to arrested drug users. Each type of outreach may require a different set of communication skills. Depending on the project's objectives, the outreach team may include several different outreach workers who complement one another and provide an appropriate mix of skills and background characteristics.

Overall, it was suggested that each job and recruitment description include

- a position title;
- specific job duties and responsibilities; and
- experience requirements.

As an example, a representative of one of the projects provided the following recruitment description for an outreach worker in that project's locale.

"Position Title: Outreach Worker, AIDS Research and Education Project

"Duties and Responsibilities: Perform AIDS prevention outreach to IV drug users, including prostitutes and homeless persons in [name of locale] and surrounding areas. Distribute literature, bleach bottles, and condoms. Engage in one-to-one interaction regarding risk reduction practices. Schedule appointments for interviews and AIDS antibody tests, and counsel each individual regarding implications of test. Must write clearly and keep records consistently.

"Previous Experience: Previous experience in AIDS education or risk reduction counseling highly desirable. Familiarity with IV drug users, prostitutes, or similar populations, and ability to interact comfortably with these individuals. Recovering drug users and persons familiar with Spanish language and culture are encouraged to apply."

Initially, job and recruitment descriptions may be somewhat general and flexible. However, in time, more specific duties, quantifiable activities, and background requirements may be added. In particular, as the staff begins to specialize, it may be necessary to stipulate a candidate's sex or ethnic background to fill a particular gap in the outreach team's composition.

Recruitment Strategies

Participants described a diversity of recruitment strategies. No single approach was preferred, but the following alternatives were suggested as examples of successful strategies. Many projects have targeted drug abuse treatment clients as the primary recruitment source for outreach workers. This approach has the advantage of targeting candidates who have known records of recovery, have been screened by professionals who are knowledgeable about drug abuse issues, and are likely to be knowledgeable about the drug culture. Another advantage of this approach is that early contact with drug treatment programs provides the AIDS outreach project with a valuable ally for future service referrals. In addition, outreach candidates who are chosen from treatment programs possess a basic knowledge of the personnel and procedures of the treatment agencies to which they may eventually refer clients. Finally, these candidates have the treatment program as a resource if they relapse.

In other instances, outreach projects have developed an informal recruitment network among street and community organization contacts in their locales. Initial participant observation and one-to-one contacts within the community provide the basis for these referrals. Known addicts and other community contacts may informally refer ex-addict or ex-prostitute candidates from their own neighborhoods. Such candidates have the obvious advantage of being truly indigenous, but they must be screened for recovery status and appropriate attitudes and abilities.

Other community agencies such as housing authorities, public health programs, employment agencies, medical facilities, and social service agencies are also excellent sources of referrals. One of the major advantages of using community agencies for referrals is that they have better knowledge of the kind of person required for outreach as well as of the individual candidate's reputation and abilities. In addition, an opening is provided for linking existing programs with the outreach project for referrals.

Several participants suggested innovative recruitment approaches, such as contacting escort agencies, sex parlors, stores that sell drug paraphernalia, suntan parlors, adult bookstores, and other unconventional sources in the community. Candidates from these source may or may not be ex-addicts, but they usually have a clear understanding of the subculture and the community.

More conventional recruitment referrals can be sought through health departments, church groups, educational institutions, ethnic social organizations, welfare

programs, job training programs, unemployment offices, the courts, law enforcement agencies, and other community organizations. In general, participants agreed that informal recruitment tactics should be implemented before or while issuing a formal job announcement. Some projects preferred to have a list of referred and screened candidates before soliciting a response from the general population.

Formal position announcements, which are part of the hiring process, present a number of problems. Respondents to a formal advertisement are likely to include only persons with conventional job histories. Formal announcements often request a resume, thereby discouraging many indigenous candidates. Although resumes should not be required for application, they should be part of the hiring process. The advertisement also may attract many candidates who are not truly indigenous to the program's geographic territory and thus make screening a burden. Nonetheless, most participants believed that position announcements and advertisements could be used judiciously to identify a pool of candidates for screening. Participants also suggested that specific characteristics of potential candidates be clearly stated in the advertisement (e.g., "Blacks, Asians, Chicanos, Cubans, Puerto Ricans, or persons with a knowledge of those communities are encouraged to apply"). The same kind of statement could be included concerning experience in drug use, prostitution, or other relevant characteristics.

Interviewing and Hiring

Participants generally agreed that once a pool of candidates has been identified, a multilevel screening, interviewing, and hiring process should be implemented. All information solicited in the interview process must be kept strictly confidential. The majority of participants agreed that the interview process should include the following steps:

1. The outreach supervisor should interview a fairly large number of potential candidates, screening out those who are not qualified and identifying those who are most desirable for the position.
2. The group of candidates who are considered most desirable should include a diversity of backgrounds (e.g., ethnicity, drug use). The advantage of having a large group of candidates is that it allows the final selection to include an appropriate mix of genders, backgrounds, and cultural requirements.
3. A second interview with a panel of selected project staff (including other outreach workers) should be arranged for those candidates who are considered most desirable. This panel identifies the most desirable candidates, and those whom it considers unacceptable should be disqualified.

4. The recommendations of the project staff panel should then be considered by the outreach supervisor and program director in reaching a decision concerning the employment offer, salary, and particular conditions of employment.

Participants suggested that the first step in the actual interview should be to delineate the specific activities and tasks that the candidates will be required to perform. Other project information, such as goals, objectives, methods, and approaches, also should be described as well as procedural matters, such as hours of operation and reporting requirements.

Participants suggested a number of highly useful, interactive methods of interviewing. Role-playing scenarios were suggested as the best way to judge how candidates may act in a real street environment. In such an approach, the interviewer suggests a situation and asks candidates how they would react. For example, the interviewer might ask, What would you do if a contact is talking to you and someone approaches to make a drug sale? Other possible questions might be, What would you do if the police pick you up in a drug raid? What would you say to someone who wants to sell you a television or other possibly stolen goods? What would you do if a contact asks you what Sally's AIDS antibody test said? These scenarios can be developed by the supervisor or lead interviewer before the interview and used to elicit information concerning the candidate's judgment, knowledge, and attitudes.

Another suggested approach was to ask candidates to demonstrate how they would perform a job task. These questions might include asking candidates what they would say when they approach a stranger with packets of condoms and bleach, what they would say if a contact asks specific questions about AIDS and sexual practices, or what the street name is for a certain drug. The scenario should elicit a judgment that is based on the particular project environment. For example, prostitutes in some cities are subject to arrest if they step off the curb to solicit customers. A question that tests candidates' knowledge of the street might be, What would you do if you are talking to a prostitute and she walks into the street? Would you follow and continue the conversation?

Another highly desirable approach is to ask candidates to evaluate their own strengths and weaknesses. Questions that solicit such information include, Why do you think that you can interest community contacts in being interviewed? How would you do that? Why should I hire you? Are there any situations that you think you couldn't handle? Would you walk into an enclosed area or shooting gallery by yourself? If you were working in a two-person team, what kind of person would you like to work with?

Concerning positions requiring bilingual skills, participants were unanimous in recommending a bilingual interview. For example, candidates being considered for outreach work with the Cuban community should be interviewed in Spanish by at least one Cuban interviewer. Participants believed that an actual conversation is the only way

to demonstrate that the candidate understands the particular dialect and knows drug and health vocabulary in that dialect. Finally, if the position requires outreach workers to keep written records, the interview should include a simple writing assignment such as, Describe the people sitting on the bus on your way here. This assignment not only tests writing abilities but also indicates how observant candidates are in informal, unstructured circumstances.

Hiring Mechanisms

With regard to hiring outreach workers, participants suggested numerous alternatives. However, hiring should be consistent with the project's normal procedures of hiring staff and follow the same hiring policies and regulations. It was generally agreed, however, that the outreach supervisor in consultation with the program director and the project staff panel should make the final selection and determine the hiring offer. Employees may be hired

- for probationary periods of varying lengths;
- after successfully completing training;
- part-time; or
- on a temporary basis (allowing the program to terminate employment if necessary).

Hiring often must be approved and authorized by a parent institution, such as a university or health department. When there is a parent organization, its standard hiring agreement should be used. At the individual project level, several alternatives may apply. However, a hiring letter, contract, letter of agreement, or similar statement that outlines duties, salaries, and benefits should be used.

With regard to hiring part-time workers, most participants believed that full-time commitments were preferable, except in unusual circumstances. This recommendation was made because of the job stress of outreach. Outreach work is very engaging mentally and requires attention not only to serving clients but also to ensuring one's own safety and well-being. In addition, hiring part-time workers creates difficulties in scheduling two-person teams as well as in allowing flexible scheduling.

4. OUTREACH STRATEGIES

Issues

A major objective of the NIDA AIDS community outreach and demonstration research effort is to demonstrate and validate effective new behavioral change strategies targeted specifically to IV drug users and their sexual partners. For these reasons, the outreach strategies of participating programs are quite diverse. These strategies include methods and resources that are unique to a given area but have not been fully validated with respect to AIDS risk reduction. Nonetheless, the history of outreach strategies for IV drug abuse interventions is considerably longer than that of the AIDS epidemic, and such approaches have served as a basis for adapting programs to the new area of AIDS risk reduction.

AIDS community outreach programs are different from conventional outreach programs for drug users in the following ways:

- Their primary objective is AIDS risk reduction rather than drug abuse counseling and treatment.
- They are often experimental.
- They involve an infectious disease that carries the dual stigmas of drug use and sexual transmission.
- They are directed at high-risk populations that are difficult to reach and sometimes invisible.
- They must address highly sensitive areas of sexual behavior change.
- They must take into consideration changing patterns of drug use as well as social and psychological conditions.
- They require one-to-one contact with a target population that has little experience with health education and may be highly skeptical of outside intervention as a result of previous experiences with punitive approaches.
- Their outreach workers are exposed to highly dangerous situations involving frequent, life-threatening physical violence.
- They must take into consideration that there is no known cure for those who are HIV infected, although treatments for AIDS-related conditions do exist.

- They have limited medical and psychosocial support resources available within client communities. Existing resources for AIDS case management are often reluctant to accept clients with a history of drug use.
- They must keep updating their knowledge of the HIV disease process and alternative treatments and services available. This information changes with unprecedented speed, requiring constant updating of health education messages.

Despite these major challenges, NIDA-sponsored AIDS community outreach and demonstration research projects have developed numerous new outreach strategies to facilitate program development. Participants described some specific approaches that have been successful in their locales as well as some unsuccessful approaches to avoid.

Understanding the Community and Its Concerns

Developing outreach strategies must first and foremost be adapted to the conditions of a specific population and a particular locale. In this respect, participants strongly agreed that no outreach effort can succeed without significant community involvement, especially the involvement of indigenous community health outreach workers.

In adapting strategies to suit each community, participants stressed the need for skilled participant observation, ethnographic mapping, observation of the changing social organization of drug use, and precise characterization of the target population. Participants stated that it was particularly important for outreach programs to determine the following:

- communication skills needed;
- existing community concerns and resources;
- appropriate messages for the community;
- opportunities for cooperative community services, such as police, church, social organizations, local government, and other potential collaborating organizations;
- appropriate sites, locations, and times for reaching outreach contacts;
- ways to gain credibility, visibility, and acceptance;
- appropriate referral patterns and links with community service providers; and

- tangible benefits to offer the community beyond risk reduction counseling efforts.

Communication Skills

Appropriate communication was perhaps the dominant theme of the meetings. Participants discussed communication skills in relation to almost every other issue of project operations. It was generally agreed that using indigenous outreach workers would not in itself ensure successful communication with the target population.

Outreach workers require training in AIDS subject matter as well as training that empowers or reinforces the worker's natural skills and personal communication style. In almost every instance, participants emphasized that nontraditional styles of communication are required. Outreach workers benefit from assistance in recognizing and enhancing communication skills that they already possess but may not have consciously labeled or used. Several projects have developed their own communication enhancement programs, and NIDA also is providing training and technical assistance in this area.

Such approaches seek to empower outreach workers to identify and expand their skills, understand the emotional and attitudinal environment within which communication takes place, and recognize their own personality strengths. The following communication skills and personal characteristics were identified as necessary for outreach workers:

- *Empathy* is the ability to understand what another person is experiencing and to communicate that understanding.
- *Respect* is showing appreciation for the dignity and worth of another human being and accepting the fact that individuals have a right to make their own decisions and manage their own lives.
- *Genuineness* is being oneself without phoniness, role playing, or defensiveness.
- *Concreteness* involves specific communications that relate to the what, why, when, where, and how of something. Concreteness keeps the client from avoiding or escaping the issues at hand.
- *Confrontation* is risky and can precipitate a crisis, but it is often through crises that changes occur.
- *Self-disclosure* means revealing one's personal feelings, attitudes, opinions, and experiences for the benefit of the client.

- *Immediacy* involves dealing with the feelings between the client and the outreach worker in the present.
- *Charisma* is the dynamic force and magnetic quality of outreach workers who are in command of themselves and able to communicate their competence and trustworthiness.

Existing Community Concerns and Responses

One of the principles of effective outreach is to secure the community's cooperation by responding effectively to the community's needs and wants. Accomplishing this cooperation requires contact, listening, soliciting advice, and responding with tangible benefits. Many participants suggested that the methods to accomplish these goals may be unrelated to the project's objectives (e.g., research and education). However, the benefits offered to the community in other areas tend to alleviate the anxiety in the community by building trust, credibility, and participation. This process is critical to the success of the outreach project and it allows a platform for the research and education to occur. The following activities can be incorporated into the scope of outreach work:

- assisting individuals through crisis interventions;
- making referrals to shelter or housing resources;
- identifying or making referrals to food distribution programs;
- identifying or making referrals to welfare agencies;
- locating or making referrals to vocational rehabilitation and job training organizations;
- participating in church and charitable and social activities;
- organizing educational meetings at which food is served or entertainment is offered in order to encourage community attendance;
- distributing free condoms and bleach;
- obtaining services from AIDS and drug rehabilitation programs as well as providing services; and
- acting as an advocate for individuals in their relations with outside organizations, such as the police, courts, housing authorities, day care

facilities, family planning agencies, and assistance programs for runaway youth.

Appropriate Messages and Message Delivery

The success of outreach communications depends not only on the personal style of outreach workers but also on the content and method of the message to be communicated. For example, each of the NIDA AIDS community outreach and demonstration research project models presents a somewhat differing message, and each is presented in a manner appropriate for a different target population. All the messages aim to provide risk reduction information to high-risk populations, but the styles of the messages must be ethnically, racially, or personally appealing and understandable to the target population.

In some ways, developing such messages and styles is similar to the marketing techniques of professional advertising. The idea is to present the information in an attractive light and to sell that information to a specific group of consumers who will benefit from the information. Likewise, behavioral changes to promote health depend heavily on the consumers' ability to recognize the benefits of the change, to internalize health risk reduction messages, and to make them a part of their attitudes, beliefs, and values.

Outreach efforts require approaching the contact with a message that is congruent with the contact's preexisting tastes, beliefs, and values. The message must be personalized; it must build on an individual's preexisting motivations; it must offer an immediate incentive to change high-risk behaviors; and it must be consistent and continuously reinforced. Commercial advertisers have long recognized that frequent repetition and reinforcement are more important than single or infrequent glamorous presentations. This reinforcement approach is considered to be most effective for outreach efforts as well. Being consistent in communication style, being available at certain places and times, and repeatedly delivering a consistent risk reduction message are all necessary conditions for successful outreach efforts.

In addition to the consistency of the outreach worker's message, often there is a consistent pattern to the client's response. The client must go through several difficult steps in accepting and personalizing a risk reduction behavior, which usually requires repeated contacts. Personal behavioral changes require the following pattern of psychological events:

- A personal crisis often precipitates the client's awareness that a high-risk behavior is real and highly dangerous.

- This awareness frequently results from a personal confrontation about high-risk behavior by a trusted friend, loved one, or someone who has already shown genuine concern for the client's well-being.
- Either immediately or gradually, the client arrives at a recognition that the message applies to him or her.
- A trusted person is available to supply new knowledge about the dangers of a high-risk behavior and a clear understanding of exactly what steps and behavioral changes are needed to reduce the threat.
- There must be a strong personalized conviction that the behavioral changes are manageable and that the client is determined to make the changes part of a permanent lifestyle.
- The client's confidence of success in achieving personal goals must be strong, and there must be successful experience in practicing the behavioral change.
- As the client experiences successes, praise from valued friends and loved ones is an important reinforcer. Moreover, such praise and support are especially reinforcing when they come from peers who have made similar behavioral changes.

Given this pattern in human learning, the credibility and consistently caring attitude of indigenous outreach workers are essential. In addition, repeated reinforcement of the risk reduction message at consistent times and locations with each individual client is indispensable.

Opportunities for Cooperation With Community Organizations

Participants repeatedly stressed the need to develop cooperative relationships with other community service organizations. Participants not only pointed out the importance of such relationships as a source of assistance and referral but also contended that failure to establish cordial relationships with other community organizations could be destructive to the project's goals. In particular, they emphasized the need to work cooperatively with religious and police organizations in communicating the project's objectives and activities. Four key areas of community cooperation were emphasized:

- justice and law enforcement agencies;
- governmental health and human service organizations;

- proprietary health care providers; and
- private religious and charitable organizations.

In the case of law enforcement agencies, participants strongly recommended early contacts with the police. The purpose of this contact is to make the project's goals known, to secure the trust of law enforcement officers, and to explain why the project must maintain a separate and confidential relationship with clients, without providing information for law enforcement purposes. It was further suggested that there should be a standard legal practice of securing a "certificate of confidentiality" for all project employees. Such a certificate, although not yet tested in its application to criminal proceedings, is intended to protect the outreach project workers from judicial demands to breach confidentiality. It potentially would exempt all records and observations from subpoena in criminal proceedings (e.g., prosecution of clients for drug sales or use).

Participants unanimously agreed that cordial relationships with law enforcement personnel are beneficial to outreach efforts. It is essential for the community to perceive the outreach worker as someone who never acts as an informer to the police, yet at the same time has the sanction of local police as a member of a legitimate community health organization. It is recommended that outreach workers display visible identification for the benefit of both the police and the community. In many instances, participants cited examples in which outreach workers acted as advocates for clients and gained the cooperation of the police in supporting health fairs and education and drug abuse prevention activities.

Participants frequently cited advance contact with religious organizations as another critical requirement. Because AIDS outreach for IV drug users involves sexual, moral, and criminal issues, each project must make it clear to religious and charitable leaders that their goals and objectives are entirely congruent with a humanitarian approach. The entire outreach project reinforces values, such as family life, protection of children and youth, education in AIDS and drug abuse prevention, and voluntary efforts encouraging healthful attitudes in the area of sexual morality.

Participants considered other governmental and private health service organizations primarily as collaborators in education and sources of referral services for both the client and the outreach project. Essentially, the service organizations can be encouraged to publicize and reinforce the AIDS risk reduction messages and act as sources of treatment for HIV infection and drug dependence as well as community psychosocial support systems. The outreach project also reinforces messages and themes on risk reduction from these organizations, when they are appropriate for the target population.

One aspect of this linkage was considered especially productive. Participants agreed that the outreach project must become familiar with community referral

organizations and the personnel who provide those services. This linkage ensures that clients can be integrated promptly into the system of health care services. Several projects have developed referral vouchers that identify persons as outreach clients and ensure that they are treated with dignity. In some cases, projects provide transportation to treatment facilities, make telephone calls to intake personnel, or even accompany the client to his or her first contact with a service provider. Such relationships require time, effort, and unusual diplomacy.

Participants highly recommended "bartering" services as one way of securing cooperation. One project exchanged a regular weekly inservice presentation on AIDS for health promotion and risk reduction for a local mission. In return, the mission took referrals from the outreach project on a priority basis. The outreach project emphasizes its own services and offers assistance to other community programs in their efforts related to AIDS and drug abuse prevention and treatment.

Appropriate Sites

There was considerable discussion of appropriate site locations for project offices and the use of the word "AIDS" in the title of the project. Despite a diversity of approaches, all participants agreed that the site should be conveniently accessible to clients and close enough to the target area to allow for fast emergency backup. Within those requirements, numerous sites were considered, such as

- mobile units for testing;
- temporary locations in motel or hotel rooms;
- storefronts;
- offices in health department facilities;
- conventional leased office space;
- facilities provided by affiliated universities or other research institutions;
- offices in buildings where other community medical and social support services are located; and
- multipurpose locations, such as a permanent administrative office combined with a mobile unit, a hotel, or another temporary location.

Hours of Operation

Hours of operation varied from project to project, depending on local needs. In general, hours of operation for administrative offices tended to conform with usual business hours. However, many projects included late night or early morning hours for outreach workers in the streets. In these cases, participants strongly recommended that backup and emergency staff must be available on call to assist outreach workers at any time.

Outreach Team Strategies

Participants identified flexible and variable strategies for assigning community health outreach workers to particular teams and locations, depending on local target population requirements. However, certain necessary procedures and precautions were recommended for any outreach effort:

- Buddy systems of two or more field personnel.
- Use of beepers or periodic telephone calls to assure field communications.
- Insistence that highly dangerous locations require an outreach team of at least two persons. Examples of such locations are any enclosed space, locations associated with previous violence, and shooting galleries (places where drug users are known to go to shoot up, or inject, drugs). Some projects do not allow outreach staff to go into shooting galleries.
- Strict adherence to a consistent itinerary and pattern of movement.
- Systems of rotating team members or dangerous territory assignments periodically to avoid burnout and risk of relapse.
- Training in emergency procedures and danger avoidance techniques.
- Use of photo identification cards for all field workers.

Letters of Cooperation

Participants agreed that the primary goals of all outreach efforts are credibility, trust, and cooperation, and they emphasized that no project can succeed separately on its own. It was further agreed that credibility, trust, and cooperation can be gained only by having a highly visible organization that can

- deliver tangible benefits to the community;
- be relied upon to keep its promises;
- cooperate with other community programs; and
- be consistent and predictable in its performance.

With regard to delivering tangible benefits, participants stressed the importance of providing intervention information and packets of condoms and bleach as well as consistently assisting with referrals to other health and community services. With regard to promises, two aspects were stressed: (1) once made, a promise must be kept, and (2) workers must not make promises that they cannot keep. Consistency involves strong worker communications and training. It requires that all workers be involved in the entire project effort and that their skills and training be updated regularly through staff meetings and formal training sessions.

With regard to community linkages, a "letter of cooperation" was suggested as a useful mechanism. This letter is a communication in which the AIDS outreach project and an individual community organization simply agree to assist each other in certain specified ways. In addition to formalizing a commitment, this letter is useful in avoiding turf battles. By generally outlining the respective responsibilities of the two organizations, it often solves problems of jealousy and territorial disputes before any real problem arises.

5. STAFF OPERATIONS AND SUPERVISION

Issues

Participants emphasized the importance of supervision and support for community health outreach workers. Participants identified the following differences between supervising outreach workers and conventional employees:

- Outreach workers often are chosen from their own neighborhoods, where they have established personal relationships that may affect worker objectivity in the field.
- Many indigenous outreach workers have not held conventional jobs; therefore, they are unfamiliar with job expectations such as hours, dress, calling in when sick, and so on.
- Outreach workers frequently are recovering from drug use and must be assisted in avoiding relapse.
- Workers in recovery may have a higher number of personal problems and crises because of their addictive behavior.
- Many workers may be infected with HIV because of their past sexual behavior or drug use.
- Outreach job skills are unusual and cannot be learned from traditional schooling or conventional employment experience.
- Outreach work is extremely stressful and dangerous.
- Outreach workers are assuming new roles within their community.
- Outreach workers are mobile and cannot be supervised in the sense of close or hour-to-hour observation.
- Outreach workers frequently become community role models and care givers, developing relationships in which clients depend on them for services and emotional support.
- There is no established pattern for career development and promotion for outreach workers.

- It is difficult to recognize accomplishments and monitor the performance of outreach workers by means of conventional methods.
- Outreach workers must have a bond with the rest of the project staff, although they are seldom located in the administrative offices.

Overall, participants agreed that supervising outreach work extends beyond evaluating performance to promoting skill development. Although many individuals may be good community outreach workers, they need additional skill development in areas such as the psychology of drug addiction and human sexuality, AIDS messages, and writing. Supervision was viewed as a method of improving success rates in meeting program goals and objectives.

Support for Outreach Workers

Outreach workers function in dangerous and stressful environments, and participants fully agreed that this effort requires unusually rigorous support measures. Because outreach members are in recovery, having daily contact with drug users and dealers can easily jeopardize their recovery programs. As a result, all projects recommended the following stress reduction and psychological support systems:

- recognition of workers' stress patterns and the need to provide support in advance of a relapse problem;
- daily or weekly opportunities for workers to communicate and vent in a team environment to relieve stress;
- provision of resources for periodic professional counseling;
- encouragement of continued participation in an active program of personal recovery for former drug users;
- opportunities for workers to spend some time away from the street environment;
- programs that promote team bonding and encouragement or rewards for the workers' success; and
- frequent staff meetings.

In terms of support, project approaches were reasonably uniform. The project supervisors considered themselves to be supportive by acting as advocates for outreach workers and helping them to resolve both personal and professional problems. They considered it their duty to maintain staff morale; keep in close communication; and

provide necessary resources, staff development, training, respect, and praise for accomplishments. They stressed the application of their personal skills in these respects and indicated that they have a responsibility to adapt their personal managerial styles to the needs of outreach workers.

Adherence to Project Rules and Procedures

Project supervisors agreed that outreach workers had reciprocal responsibilities in terms of following project procedures and working diligently to achieve objectives. Generally, the approaches suggested were designed to be flexible. However, certain ground rules for outreach work were emphasized. There are some outreach do's and don'ts to which there can be no exceptions. Specifically, violation of these rules may be immediate cause for dismissal. The following rules should be clearly stated and understood.

- *Do* carry identification at all times.
- *Do* let contacts know the limits of your job.
- *Do* maintain confidentiality.
- *Do* emphasize the value of your job and the loss if you or your job is endangered.
- *Do* keep your supervisor or coworkers advised of your whereabouts.
- *Do* consult your supervisor about any difficult situation.
- *Do* offer any reasonable assistance that is requested.
- *Do* work in pairs.
- *Do* maintain relations with police as established in ground rules with the police chief.
- *Do* be mindful of the media.
- *Do* maintain support for recovering workers.
- *Don't* drink or take drugs on the job.
- *Don't* buy or receive drugs.
- *Don't* buy or receive property of any value from clients.

- *Don't ask about or listen to trafficking information (except to locate outreach areas).*
- *Don't buy or accept sexual favors from clients.*
- *Don't hang out with persons who you know are carrying drugs.*
- *Don't receive, carry, or confiscate weapons.*
- *Don't give money directly to clients.*

Reporting Requirements

Although many of the activities of community health outreach workers are difficult to evaluate, participants agreed that certain forms of quantitative reporting are helpful in monitoring performance and in improving effectiveness. Participants suggested the following kinds of quantifiable activities as useful monitoring approaches:

- having check-in and checkout times;
- keeping daily logs or reporting the number of contacts made each day, including a brief description of each encounter;
- maintaining records of the number of persons referred for interview, testing, counseling, or followup counseling as well as social service referrals;
- requiring periodic telephone contacts with the administrative office and supervisor; and
- performing occasional supervisory field visits and keeping records of observations.

Participants suggested that these recommendations could be considered as possible criteria for assessing the performance of outreach workers. However, there was no agreed-upon minimal level of activity. Projects varied in the number of contacts, referrals, interviews, and followup counseling visits that they considered satisfactory.

Operations Manuals

Meeting participants suggested numerous approaches to documenting operating procedures and expectations. Most projects perceived a need to develop an operations manual to describe all administrative procedures. Many participants stressed the need to develop procedures early in project development. Although these procedures can be

refined over time, an initial draft should be developed before hiring and program implementation. It was suggested that procedures could be developed from the minutes of staff meetings and then formalized for the manual. The operations manual should include the following:

- agency goals and objectives;
- project description and activities;
- job descriptions for outreach workers;
- supervisory authority;
- hours of operation;
- team assignments and geographic areas of operations;
- task descriptions;
- education and intervention approach;
- target population information;
- expected activity levels;
- reporting requirements;
- training requirements;
- salary;
- leave;
- benefits; and
- personnel procedures.

Employee Orientation and Guidance

Participants generally agreed that employees should have access to the job descriptions for all their colleagues. This practice allows new employees to understand their relationship to other project staff and to know where to turn for assistance or advice concerning problems. It also gives employees a sense of the continuity of the project as a whole and allows them to form an identity as specialized members of a

multidisciplinary staff. Finally, it helps orient workers to the varied outreach, data collection, ethnographic, and research activities of the overall project team.

Supervisory Authority and Employee Roles

Participants agreed that supervisory authority requires a clear and broad definition. They suggested that the project operations manual should identify not only the outreach worker's immediate supervisor but also the entire chain of command from the project director to the outreach staff. Outreach workers need to be aware of the levels of authority to which their own supervisor must answer. This awareness facilitates understanding of the appropriate channels of communications. It also explains the areas in which one's immediate supervisor is authorized to make decisions as well as the areas that require approval of other project officials. An organizational chart is also a useful tool for illustrating supervisory and communications channels.

Appropriate Work Scheduling

Opinions differed widely regarding hours of operation for outreach projects. Overall, most participants agreed that the hours of operation must be standard (i.e., the same for the outreach project, the agency, and all employees). Nearly all projects indicated that the administrative or supervisory staff must be on call when outreach workers are in the field to answer questions, give referral advice, and ensure a point of communication for safety reasons.

However, projects differed on specific times of operation, usually as a function of whether the target population is on the street in early morning or at night. All participants clearly agreed on two inflexible standards that need to be understood before hiring:

- Once hours of operation have been assigned, all workers must observe them regardless of personal preferences.
- When double shifts or late night hours are required, a backup staff must be on call, and a procedure for providing emergency support to workers in dangerous environments must be in place.

A hiring agreement should be considered a commitment to maintaining the standard hours of operation.

Team Assignments

Team assignments, although not universal, were frequently used approaches to community outreach. Some project staff believed outreach workers would be safe alone on the street, but others used two-person teams and a variety of communication devices,

such as beepers and periodic telephone check-ins. Some projects used rotating team assignments, which provide less opportunity for relapse and failure to abide by rules. Rotating teams enhances team building by providing opportunities for workers to give one another feedback, especially on risk reduction messages, recruitment techniques, content of field notes, and development of relationships with community members. Some participants advocated a two-member male and female team both for dealing with sexual partners and for safety. Specific staff arrangements depend on local needs, but the operations manual should state the project's chosen approach regarding street teams and should make employee assignments clear.

Task Assignments and Workloads

Many participants believed that specific tasks for each employee should be stated as part of the job description. Such tasks include educating on AIDS prevention, making contacts, screening contacts, referring contacts for interviews, keeping daily logs or activity reports, writing contact descriptions, attending meetings, dispensing condoms or bleach, and providing transportation to outreach sites.

Many project participants also believed that employees should be required to perform a daily quota of certain tasks, such as making a minimum number of contacts, scheduling a minimum number of interview referrals and risk reduction sessions, and distributing a designated number of condoms and bleach packets. Opinions concerning the appropriate number of activities per day differed depending on the model and the nature of the project's target areas and populations.

Training Requirements

Participants suggested that employees should be informed of any required training at the initial interview. Such training should be described and agreed upon before employment.

Salary, Benefits, and Leave

Participants described many different provisions for salary levels, benefits, and leave. Although there was considerable variation, the following recommendations were stressed:

- Benefits and leave should be the same for all project staff.
- Salary must be at least a living wage for the geographic area; it should never be so low as to require outreach workers to seek supplemental earnings.
- Projects need to provide liberal benefits for outreach staff, such as leave for personal problems and assistance to prevent relapse.

Finally, participants suggested that it is foolish to sacrifice the quality and commitment of the outreach staff by being overly concerned with economy. Employees who receive respectable wages and benefits are more likely to perform well.

Considerations Regarding HIV-Positive Staff

Participants suggested that projects develop a plan for HIV-positive staff members like the one for recovering drug users. This plan should include alternative work assignments in the event of illness. Such plans require support, backup workers in case of illness, and means to offer additional sick leave--or at least leave without pay, if sick leave is exhausted.

It is not unusual for AIDS outreach staff to be HIV positive. In this regard, the following generally accepted practices were suggested:

- HIV-positive status is not considered grounds for termination under any circumstances.
- HIV status should be kept confidential unless workers choose to reveal their status.
- HIV-positive staff members should receive stress management and appropriate counseling support in the same way that workers would be supported if they were in danger of relapse or other clinical problems. (A number of projects stated they had or were implementing stress management programs for their entire staff.)
- Although it is usually not possible to provide special benefits for HIV-positive staff members, they should receive the same health insurance coverage, the same sick leave, and the same kinds of support that are available to other workers.
- Participants suggested that HIV-positive staff members should be granted leave without pay if their illness lasts longer than their accumulated sick leave.
- It also was suggested that HIV-positive staff members should be assured that they may return to work whenever their physical condition permits.
- Depending on local laws, available insurance coverage, and applicable medical and psychological support resources, projects should assist HIV-positive employees in obtaining the best medical care and third-party payment available under the circumstances. This policy requires an active effort on the part of outreach projects to help identify appropriate health

care providers and special high-risk insurance carriers that will accept HIV-positive persons.

- Illness and death resulting from AIDS can have detrimental effects on staff morale. Projects should make special provisions for support groups and other stress management mechanisms in the event of a coworker's illness, hospitalization, or death. Also, projects should provide support groups to deal with the effects of losing a client.
- Participants generally agreed that it is preferable for HIV-positive workers to conceal their status from clients and contacts in the field, because it may be misunderstood or cause them to be avoided by contacts who are misinformed about contagion.
- Projects should anticipate more frequent absences of staff with chronic illness and should make arrangements for backup or floating staff who can fill the gap in the event of absence or illness.

Personnel Procedures

In the area of personnel procedures, participants suggested that documentation should include who is responsible for the following:

- providing daily communications with employees;
- providing staff support and assistance;
- assisting with benefits claims;
- approving assignments;
- providing technical assistance and training;
- assisting in problem solving;
- addressing grievances and appeals;
- recording working hours;
- administering benefits;
- coordinating the payroll;
- approving leave or vacation;

- reviewing performance; and
- making hiring or termination decisions.

Equality of Involvement

All the participants stressed the importance of giving outreach workers a sense of accomplishment and involvement. Outreach workers should be encouraged to participate in the full range of project activities and decisionmaking processes. It was suggested that outreach workers should participate in the following activities:

- meetings of the full staff;
- preparation of renewal grant applications;
- review of budgets;
- procedures development;
- development of training plans;
- authorship of publications;
- activities aimed at recognition of program accomplishments;
- interviews with the press or visiting officials;
- planning for staff assignments and the replacement of personnel lost to attrition;
- orientation processes that involve the full range of program activities from research to street outreach;
- meetings with higher authorities within a parent organization; and
- meetings with community leaders.

A major goal of outreach work is the bonding and commitment of a team dedicated to the same objectives and sharing the same values in an atmosphere of trust, cooperation, and mutual respect. Without this bonding, the team lacks cohesion and becomes fragmented in its approach. Beyond formal activities, many participants suggested that projects include activities such as picnics, dinners, and other gatherings.

Career Development

One of the most important topics discussed at the meeting was the need for projects to provide career development for each outreach worker. In many cases, outreach work may be the first professional position an individual has held.

Most outreach projects function on 3-year limited funding, and outreach workers need to understand that the skills they are acquiring can be applied to other employment situations. If workers perceive their jobs as dead-end positions, maintaining morale is difficult. Therefore, participants stressed the need to consider outreach workers as professionals who can grow within the organization or move on to challenging opportunities in other organizations.

To build career development paths, participants suggested the following methods:

- performance reviews with opportunity for promotions or merit raises;
- development of professional standards that lead to training certification for outreach workers;
- continuing education and training with academic credit; and
- tuition assistance programs for those workers who choose to pursue formal education.

Participants also suggested frequent reinforcement for outreach workers concerning the importance of their current assignments. It was suggested that workers be reminded of their positions as community role models, positive agents for change in existing social conditions, and examples of integrity and commitment for their own people. Participants repeatedly stressed the need to listen carefully to the suggestions, opinions, and experiences of outreach workers in order to learn from them. Finally, participants suggested that outreach workers require constant reinforcement for small successes, such as receiving repeat requests for bleach or condoms, obtaining a referral for treatment, witnessing individuals sterilizing their syringes, or seeing clients cooperate in giving interview data or accept risk assessment counseling.

The environment within which outreach workers operate is often illicit, slow to change, and discouraging. This negativity must be offset by emphasizing positive values and personal achievement. Participants agreed that maintaining positive attitude is difficult in the face of a deteriorating social condition beset with a rapidly spreading epidemic. The emphasis must be on the few successes that are within the workers' potential areas of control. Outreach workers may consider some of their achievements to be minor. However, in contrast with the desperation of the overall target population, small successes should be viewed as genuine victories.

6. TRAINING

Issues

Training community health outreach workers requires an individualized approach tailored to the needs of each of the numerous NIDA-supported AIDS community outreach and demonstration research projects. For this reason, one of the primary objectives of the meetings was to ask the participants to assess the training needs of their staffs. Participants did so with the caveat that they would confer further with individual workers and that any training program requests would be based on the perceived needs of both the supervisors and the outreach staff.

The following training issues were identified as unique for outreach workers:

- orientation to a process of self-assessment that consciously recognizes skills or deficiencies that are usually unrecognized;
- a range of personality and background skills that cannot be taught but can be brought into conscious application through enhancement and empowerment techniques;
- certain kinds of didactic training (e.g., the progression of HIV infection and related health information, and updated AIDS information);
- some areas of remedial education, such as ordinary living and budgeting skills, literacy skills, and recordkeeping;
- problem-solving skills;
- training in platform delivery for community inservice training;
- procedures training;
- role-play training to facilitate competency in risk reduction and health promotion messages; and
- training in networking with community resources.

To address specific training needs, each project is developing an individual training plan for its staff. The training plans will be based on a needs assessment, which also will determine which of NIDA's technical assistance and training modules will be made available.

Participants agreed that they would be developing their own training programs with the assistance of NIDA trainers. These training programs will be based on certain interactive modes of existing training curriculums that have proven more effective than didactic methods. These modes emphasize empowerment, skill enhancement, transferral skills, role-playing and problem-solving exercises, and trainee feedback and self-assessment of training outcomes. In addition, some traditional materials and approaches also may be required in specific areas. For example, all projects recognized a need for AIDS education updates in the form of seminars or written and audiovisual materials.

Ethnographic observation was another area in which participants agreed that outside specialists might be useful. It was suggested that glossaries of street language and handbooks of street outreach procedures be developed to provide examples of possible situations that workers might encounter and how the situations might be handled. It also was suggested that each project develop a handbook of referral resources within its community, including information on contact personnel, hours, and guidelines for services.

Mentorship

In addition to formal training, participants identified mentorship as the preferred system of training. Several projects have been operational for some time, but others are just beginning. Therefore, participants requested that staff from established projects be available for telephone consultations concerning successful approaches to operation. Such a mentorship system would be extremely supportive and responsive. In addition, it would be inexpensive and is a sound educational approach (e.g., it is an exchange of technologies and experience among organizations with similar needs).

The list of programs, telephone numbers, and contact persons presented in appendixes C and D is intended to facilitate mentorship activities. In addition, participants suggested periodic conferences, an exchange of written project materials, and centralized distribution of printed materials such as job descriptions, posters, dictionaries, and handbooks to facilitate communication among projects.

Appendix A

AIDS Outreach Project Policy and Procedure Problem Resolution Model: Problem Analysis Diagram

POLICY AND PROCEDURE PROBLEM RESOLUTION MODEL: PROBLEM ANALYSIS DIAGRAM

***Instructions:** Following is a model for Problem Resolution that can be applied to the development and revision of program policy and procedure. In each of the three workshops, you will be asked to apply this model to the category being considered (#1 Hiring, #2 Outreach Strategies, #3 Staff Supervision). (The assessment process you have completed is the initial step required for effective application of this model and will also constitute an internal frame work for ongoing assessment of progress on policy and procedure development tasks.) Using the worksheets provided, please work each step in sequence, using the expertise of the other workshop participants for technical assistance. The model consists of 7 steps:*

1. Define and state problem(s) in priority order
2. Define your goal(s) and prioritize
3. Determine conditions that will promote and those that will inhibit reaching goals
4. Determine actions that will maximize promoters and reduce inhibitors
5. Develop an action plan to include
 - a. specific action steps
 - b. resources required
 - c. delineation of responsibilities
 - d. timelines
 - e. review points
6. Implementation of action plans
7. Assessment and evaluation of plan

POLICY AND PROCEDURAL DEVELOPMENT: AN AIDS OUTREACH PROJECT ASSESSMENT AND PROBLEM RESOLUTION MODEL

Program Name: _____

RATING SCALE:

0 = not needed	2 = in place: needs revision
1 = needed: not in place	3 = in place: O.K.

Instructions: This exercise is designed to assist you in determining where your program is in its developmental process. In the left margin, rate each item under the general categories below with a number corresponding to the activity's status in your program at this time (see scale above). Then, review each category's itemized ratings and assign an overall rating to the category.

Category

A. HIRING POLICIES AND PROCEDURES

1. Job descriptions:
 - _____ a. Project Director or Coordinator
 - _____ b. Staff Supervisor
 - _____ c. Training Coordinator
 - _____ d. Outreach Workers
 - _____ e. Interviewers
 - _____ f. Ethnographers
 - _____ g. Community Education Specialist
 - _____ h. Other _____
- _____ 2. General criteria for employee selection
- _____ 3. Advertising for positions available
- _____ 4. Collection and ranking of resumes
- _____ 5. Interviewing and selection process

6. Employee orientation process

- _____ a. Employee contracts
- _____ b. Personnel policy manual
- _____ c. Flow charts
- _____ d. Facility operational procedures
- _____ e. Program/employee rules and regulations
- _____ f. Employee benefits package
- _____ g. Sign-off on Confidentiality laws
- _____ h. Other _____

_____ 7. Vacation, sick and mental health leave time

Category

B. OUTREACH STRATEGY POLICIES AND PROCEDURES

- _____ 1. Model for collection of ethnographic data
- _____ 2. Data collection forms designed and/or updated
- _____ 3. Documentation of findings of community needs assessment
- _____ 4. Procedure for service-oriented application of data
- _____ 5. Methodology for interaction/cooperation with enforcement agencies
- _____ 6. Methodology for interaction/cooperation with related support services for outreach clientele
- _____ 7. Referral contracts developed, signed and operational for services including:
 - _____ a. a range of addictions treatment modalities
 - _____ b. general medical services
 - _____ c. HIV and AIDS related medical services
 - _____ d. financial assistance
 - _____ e. legal assistance
 - _____ f. psychological services
 - _____ g. suicide and other crisis services
 - _____ h. GYN and prenatal care
 - _____ i. family counseling and support
 - _____ j. other _____

- _____ 8. Target audience in the community identified
- _____ 9. Printed materials developed or collected to speak to identified target audience
- _____ 10. Community advisory board established and functional
- _____ 11. Materials reviewed by community board and tested for sensitivity to differing cultural needs
- _____ 12. Prevention/intervention messages designed
- _____ 13. Staff consistent in delivery of messages for purposes of quality control in the community
- _____ 14. On-street behavioral protocol developed
- _____ 15. Other _____

Category

C. STAFF SUPERVISION POLICIES AND PROCEDURES

- _____ 1. Project flowchart and supervisory structure documented and clarified with staff
- _____ 2. Job descriptions delineate special duties, including:
 - _____ a. community based educational presentations
 - _____ b. materials design/redesign and research
 - _____ c. resource network contact and referral
 - _____ d. in-house training development
 - _____ e. assignment to special populations
 - _____ f. Other _____
- _____ 3. Structures in place/models defined for supervision of:
 - _____ a. individual outreach workers
 - _____ b. team/group
 - _____ c. support staff
 - _____ d. volunteers
 - _____ e. other _____

4. Structures in place for supervision:
- ☐ a. in-house
 - ☐ b. on street
 - ☐ c. other _____
5. Staff aware of accountability requirements regarding:
- ☐ a. on-street behavioral protocol
 - ☐ b. paper documentation requirements
 - ☐ c. structuring of on-duty time
 - ☐ d. use of leave time
 - ☐ e. other _____
- ☐ 6. Employee performance evaluation tools
- ☐ 7. Procedures for documenting employee infractions of rules
- ☐ 8. Employee grievance process
- ☐ 9. Procedure for employee dismissal
- ☐ 10. Routine or special staff support groups for stress reduction
- ☐ 11. Coordination of resources/referral for staff health care
- ☐ 12. Staff training/development plan
- ☐ 13. Employment skills training resources available to staff (i.e., reading, writing, time management, organization)
- ☐ 14. Other _____

Appendix B
Workshop Problem Analysis and Resolution Instrument

This instrument was used by participants for the following issues in three separate workgroups:

- (a) Hiring Practices and Procedures**
- (b) Outreach Strategies Policy and Procedures**
- (c) Staff Supervision: Policy and Procedures**

I. Problem Statement. Based on my assessment of the above issue within my program, the areas most in need of development or revision (in priority order) are:

1. _____
2. _____
3. _____

II. Defining Goals. Based on these problems, my goals for resolution (statements of desired outcome) are:

1. _____
2. _____
3. _____

III. Promoters and Inhibitors. Conditions that will promote my achieving these project goals are:

1. _____
2. _____
3. _____

IV. Maximizing Promoters, Reducing Inhibitors. Proactive steps I can take to reduce development inhibitors are:

1. _____
2. _____
3. _____

- V. **Action Planning Steps.** Based on the above analysis, the specific actions that must be taken (in priority sequence) in order to achieve my project goals are: (Please use as much space as necessary to note specific actions related to each of your priority goals.)

1. _____
2. _____
3. _____

Resources (e.g., additional \$, NIDA technical assistance, etc.) required to implement these actions:

1. _____
2. _____
3. _____

Who will take responsibility for implementing these actions:

1. _____
2. _____
3. _____

To what timeline will the project hold itself accountable:

1. _____
2. _____
3. _____

Significant actions/events that will signify review points (ongoing assessment for action planning:

Appendix C

NIDA Directory of Community Outreach and Demonstration Research Projects

COMMUNITY OUTREACH AND DEMONSTRATION RESEARCH PROJECTS

FEBRUARY 1989

Some of the projects listed in this directory have been completed and are no longer being funded by NIDA. In certain cases the State has picked up the outreach portion of the project.

ARIZONA

Phoenix

The Circle Education and Risk Assessment Project
2210 North 7th Street, Suite A
Phoenix, AZ 85006
(602) 255-0747

Site Coordinator: Steve Redvick

Training Coordinator: Linda Van Den Bossche,
(703) 821-8955

Subcontracted by:

The Circle, Inc.
8201 Greensboro Drive, Suite 600
McLean, VA 22102
(703) 821-8955

Principal Investigator: Sandra Baxter

Training Coordinator: Linda Van Den Bossche

W.A.R.N. Project

402 West Roosevelt Street, Suite G
Phoenix, AZ 85002
(602) 256-9276

Community Coordinator: Jan Kenney, M.S., R.N.

Training Coordinator: Jan Kenney, M.S., R.N.

Subcontracted by:

W.A.R.N. Project
5024 Thurber Lane
Santa Cruz, CA 95065
(408) 476-5507

Principal Investigator: Josette Mondanaro, M.D.

Training Coordinator: Josette Mondanaro, M.D.

Tucson

Amity, Inc./Community Outreach Project on AIDS in
Southern Arizona (COPASA)

316 South 6th Avenue
Tucson, AZ 85701
(602) 792-3131

Principal Investigator: Peggy J. Glider,
(602) 884-7413, (602) 749-5980

Co-Principal Investigator: Tony Estrada, Ph.D.,
(602) 626-7946

Project Director: Sally Stevens, Ph.D.,
(602) 792-3131, (602) 792-9602

Training Coordinator: Sally Stevens, Ph.D.

Subcontracted by:

Tucson AIDS Project
IV Drug Program

151 South Tucson Boulevard

Suite 252

Tucson, AZ 85716

(602) 322-6226

Project Director: Amy DeGroff

CODAC Behavioral Health Services, Inc.

2530 East Broadway, Suite A

Tucson, AZ 85716

(602) 327-4505

Outreach Coordinator: Stephen Trujillo

CALIFORNIA

Long Beach

California State University - Long Beach

AIDS Research and Education Project

Psychology Department, Room 440

1250 Bellflower Boulevard

Long Beach, CA 90840

(213) 985-7508

Principal Investigator: Fen Rhodes, Ph.D.

Co-Principal Investigators: Nancy Corby, Ph.D., David J.
Martin, Ph.D., and Lourdes Arguelles, Ph.D.

Project Coordinator: Donna Yankovich, M.A.,
(213) 491-0230

Training Coordinator: Fen Rhodes, Ph.D.

Our Place

1229 Cedar Avenue

Long Beach, CA 90813

(213) 491-0230

Los Angeles

Perinatal AIDS Outreach Project

11900 Compton Avenue

Trailer #5

Los Angeles, CA 90059

(213) 583-2555

Principal Investigator: Milton Lee, M.D.

Site Coordinator: Marva Bush

Training Coordinator: Barbara Stanley, (617) 492-7100

Outreach Training Coordinator: Benjamin Bowser, Ph.D.

CALIFORNIA (continued)

Los Angeles (continued)

Youth Environment Study, Inc.

1779 Haight Street

San Francisco, CA 94117

(415) 751-4221

Principal Investigator: Patrick L. Biernacki

Co-Principal Investigator: Harvey Feldman

Training Coordinator: Pat Norman

Santa Cruz

W.A.R.N. Project

5024 Thurber Lane

Santa Cruz, CA 95085

(408) 476-5507

Principal Investigator: Josette Mondanaro, M.D.

Training Coordinator: Josette Mondanaro, M.D.

COLORADO

Denver

Project Safe

IV/AIDS Project

1827 Gaylor Street

Denver, CO 80208

(303) 831-4433

Project Coordinator: Stephen K. Koester, Ph.D.,

(303) 831-4433

Project Co-Coordinator: George Burke

Training Coordinator: George Burke

Subcontracted by:

AIDS Outreach Intervention Project (M/C 925)

Epidemiology-Biometry Program

University of Illinois

School of Public Health

2121 West Taylor Street, Room 555

Chicago, IL 60612

(312) 998-5523

Principal Investigator: Wayne Wiebel, Ph.D.

Training Coordinator: Wayne Wiebel, Ph.D.

CONNECTICUT

Bridgeport

Greater Bridgeport AIDS Project

Bridgeport Women's Project

205 Middle Street

Bridgeport, CT 06604

(203) 335-4830, 335-4304

Community Coordinator: Elizabeth Good

Training Coordinator: Sandra Vining

Subcontracted by:

ABT Associates

55 Wheeler Street

Cambridge, MA 02138

(617) 492-7100

Principal Investigator: Ted Hammett, Ph.D.

Training Coordinator: Ted Hammett, Ph.D.

Hartford

Institute for Community Research

999 Asylum Avenue

Hartford, CT 06105

(203) 278-2044

Principal Investigator: Merrill Singer,

(203) 527-0856

Co-Principal Investigator: Jean Schensul

Project Director: Margaret Weeks

Training Coordinator: Margaret Weeks

Outreach Coordinator: Ray Irimizarry, (203) 527-0856

Hispanic Health Council

96 Cedar Street

Hartford, CT 06106

(203) 527-0856

New Haven

Community Health Education Project

APT Foundation, Inc.

904 Howard Avenue, Suite 2A

New Haven, CT 06519

(203) 785-0705

Principal Investigator: Bruce J. Rounsaville

Project Director: Andy Grunebaum

Research Coordinator: Indu Ahluwalia, M.P.H.,

(203) 562-0760

Community Outreach Project Director: Barbara Whitt,

(203) 562-0760

Training Coordinator: Jill Strawn, (203) 562-0760

Community Health Education Project

540 Ella T. Grasso Boulevard

New Haven, CT 06519-1898

(203) 562-0760

DISTRICT OF COLUMBIA

Washington

Second Genesis, Inc.

1320 Harvard Street, NW

Washington, DC 20009

(202) 234-6800

Project Director: Beck Young

Training Coordinator: Beck Young

Project S.A.F.E. of Second Genesis, Inc.

1940 14th Street, NW

Washington, DC 20009

(202) 387-3613

DISTRICT OF COLUMBIA (continued)

Washington (continued)

Subcontracted by:

Marathon House, Inc.
131 Wayland Avenue
Providence, RI 02906
(401) 331-4250

Principal Investigator: Roy Ross

Training Coordinator: Sarah Reynolds

Department of Human Services

Commission of Public Health

ADASA

1300 First Street, NE
Washington, DC 20002
(202) 727-1572

Principal Investigator: Larry J. DeNeal

Project Director: Robert Coleman, M.D.

Training Coordinator: Robert Coleman, M.D.

Outreach Project Director: Mahmoud Baptiste

Project CLEAN

2041 Martin Luther King, Jr., Avenue, SE, LL-7
Washington, DC 20020
(202) 889-4364

KOBA Institute, AIDS Division

1156 15th Street, NW, Suite 200
Washington, DC 20005
(202) 328-5700

Principal Investigator: Judy Walton, Acting

Project Director: Judy Walton, Acting

Training Coordinator: Judy Walton

AIDS Research Director: Alice Kroliczak

FLORIDA

Miami

University of Miami School of Medicine

Health Services Research

Medical Arts Building, Room 309
1550 NW 10th Avenue
Miami, FL 33136
(305) 547-6005

Principal Investigator: Clyde McCoy, Ph.D.

Co-Principal Investigator: Dale Chitwood, Ph.D.

Project Coordinator: Carolyn McKay, (305) 547-6005

Training Coordinator: Carolyn McKay, (305) 547-6005

Tampa

Tampa Hillsborough Action Program (THAP)

1920 East Hillsborough, Suite 204

Tampa, FL 33610

(813) 237-2359

Project Coordinator: Al Turner

Subcontracted by:

TRESP Associates, Inc.

4900 Seminary Road, Suite 700

Alexandria, VA 22311

(703) 845-9400

Principal Investigator: Jennifer Keyser-Smith

Training Coordinator: Bert Phillips

GEORGIA

Atlanta

Macro Systems, Inc.

3 Corporate Square, NE, Suite 370

Atlanta, GA 30329

(404) 321-3211

Principal Investigator: Stephen Margolis

Training Coordinator: Kimberly Lewis

HAWAII

Honolulu

Communicable Disease Division

Hawaii State Department of Health

P.O. Box 3378

Honolulu, HI 96801

(808) 548-4580

Principal Investigator: Dr. Robert Worth

Project Director: Sena Gates

Training Coordinator: Sena Gates

Research Director: Bart Aronoff

CHOW Project

715 South King Street, Suite 420

Honolulu, HI 96813

(808) 528-3619

ILLINOIS

Chicago

AIDS Outreach Intervention Project (M/C 925)

Epidemiology-Biometry Program

University of Illinois

School of Public Health

2121 West Taylor Street, Room 555

Chicago, IL 60612

(312) 996-5523

Principal Investigator: Wayne Wiebel, Ph.D.

Training Coordinator: Wayne Wiebel, Ph.D.

LOUISIANA

New Orleans

Desire Narcotic Rehabilitation Center, Inc.
3307 Desire Parkway
New Orleans, LA 70126
(504) 945-8885

Executive Director: Vernon Shorty
Training Coordinator: Vernon Shorty
Subcontracted by:

Research Triangle Institute
P.O. Box 12194
Research Triangle Park, NC 27709
1-800-334-8571

Principal Investigator: J. Valley Rachal
Training Coordinator: J. Valley Rachal

AIDS Outreach Demonstration Research Project
Desire Narcotic Rehabilitation Center, Inc.
3307 Desire Parkway
New Orleans, LA 70126
(504) 822-3100
Principal Investigator: Vernon Shorty, (504) 945-8885
Training Coordinator: Adelbert Jones

MARYLAND

Baltimore

PNC-NIDA
Box 101

University of Maryland Hospital
220 South Green Street
Baltimore, MD 21201
(301) 328-6326

Site Coordinator: Mary Jane Reynolds, (301) 727-2295
Training Coordinator: Millie Braunstein, R.N., M.N.,
(313) 259-1399

Subcontracted by:

Personalized Nursing Corporation, P.C.
100 Renaissance Center, Suite 1585
Detroit, MI 48243
(313) 259-1399

Principal Investigator: Marcia Andersen, Ph.D.
Training Coordinator: Millie Braunstein, R.N., M.N.

Health Education Resources Organization
101 West Read Street
Baltimore, MD 21201
(301) 685-1180

Project Coordinator: Theresa Mason, Ph.D.
Training Coordinator: Theresa Mason, Ph.D.

Subcontracted by:

AIDS Outreach Intervention Project (M/C 925)
Epidemiology-Biometry Program
University of Illinois
School of Public Health
2121 West Taylor Street, Room 555
Chicago, IL 60612
(312) 996-5523

Principal Investigator: Wayne Wiebel, Ph.D.
Training Coordinator: Wayne Wiebel, Ph.D.

Hyattsville

The Circle Education and Risk Assessment Project
5109 Baltimore Avenue
Hyattsville, MD 20781
(301) 209-8400

Site Coordinator: Bobbi Kilehia
Training Coordinator: Linda Van Den Bossche,
(703) 821-8955

Subcontracted by:

The Circle, Inc.
8201 Greensboro Drive, Suite 600
McLean, VA 22102
(703) 821-8955

Principal Investigator: Sandra Baxter
Training Coordinator: Linda Van Den Bossche

Silver Spring

Birch and Davis Associates, Inc.
8905 Fairview Road, Suite 300
Silver Spring, MD 20910
(301) 589-6760

Principal Investigator: Ann M. Downing, Ph.D.
Training Coordinator: Tina Stackhouse

MASSACHUSETTS

Boston

Project Outreach
875 Massachusetts Avenue, 7th Floor
Cambridge, MA 02139
(617) 547-1147

Principal Investigator: William E. McAuliff
Project Director: Paul Breer, (617) 864-9115
Research and Outreach Director: Glenda Kaufman Kantor,
(617) 864-9115
Clinical Director: Kurt Halliday

ABT Associates
55 Wheeler Street
Cambridge, MA 02138-1168
(617) 492-7100

Principal Investigator: Ted Hammett, Ph.D.
Training Coordinator: Ted Hammett, Ph.D.

ABT Associates
55 Wheeler Street
Cambridge, MA 02138-1168
(617) 492-7100
Principal Investigator: Dana Hunt, Ph.D.
Project Director: Barbara Stanley
Training Coordinator: Barbara Stanley

School of Public Health
Social and Behavioral Sciences

MASSACHUSETTS (continued)

Boston University School of Medicine
85 East Newton Street
Boston, MA 02118-2389
(617) 638-5160

Principal Investigator: Hortensia Amaro, Ph.D.
Training Coordinator: Barbara Stanley, (617) 492-7100

MOM's Project
Boston City Hospital
House Officers' Building, Room 404
818 Harrison Avenue
Boston, MA 02118
Site Coordinator: Genita Ekpenyong, M.D., M.P.H.
Subcontracted by:
ABT Associates
55 Wheeler Street
Cambridge, MA 02138-1168
(617) 492-7100
Principal Investigator: Dana Hunt, Ph.D.
Project Director: Barbara Stanley
Training Coordinator: Barbara Stanley

Women, Inc.
244 Townsend Street
Dorchester, MA 02121
(617) 427-9278
Community Coordinator: Kattie Portis, M.A.
Training Coordinator: Kattie Portis, M.A.
Subcontracted by:

W.A.R.N. Project
5024 Thurber Lane
Santa Cruz, CA 95065
(408) 478-5507
Principal Investigator: Josette Mondanaro, M.D.
Training Coordinator: Josette Mondanaro, M.D.

MICHIGAN**Detroit**

Personalized Nursing Corporation, P.C.
100 Renaissance Center, Suite 1585
Detroit, MI 48243
(313) 259-1399
Principal Investigator: Marcia Andersen, Ph.D.
Clinical Director: Millie Braunstein, R.N., M.N.
Training Coordinator: Millie Braunstein, R.N., M.N.

Detroit Receiving Hospital and University Health Center
PNC-NIDA
4201 St. Antoine
Detroit, MI 48201
(313) 745-4523
Site Coordinator: Jannie Tinsley
Training Coordinator: Millie Braunstein, R.N., M.N.,
(313) 259-1399
Subcontracted by:
Personalized Nursing Corporation
100 Renaissance Center, Suite 1585
Detroit, MI 48243

(313) 259-1399

Principal Investigator: Marcia Andersen, Ph.D.
Training Coordinator: Millie Braunstein, R.N., M.N.

MINNESOTA**St. Paul**

Twin Cities IV Drug/AIDS Research and Demonstration
Project
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NEW JERSEY**Atlantic City**

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Camden

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Project Director: Carol Carpenter
Project Co-Director: Dennis Gilliam
Training Director: Carol Carpenter
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Research Triangle Institute
P.O. Box 12194
Research Triangle Park, NC 27709
1-800-334-8571
Principal Investigator: J. Valley Rachel
Training Coordinator: J. Valley Rachel

NEW JERSEY (continued)

Jersey City

Spectrum Health Care, Inc.

430 Johnston Avenue

Jersey City, NJ 07304

(201) 451-2544

Project Director: Edward Cox

Training Coordinator: Elizabeth Martin-Crockett,

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New Jersey Department of Health - Jersey City Grant

20 Evergreen Place

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(201) 266-1910

Principal Investigator: Harvey Musikoff, Ph.D., M.P.H.,

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Co-Principal Investigator: Bob Baxter

Training Coordinator: Bob Baxter

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20 Evergreen Place

East Orange, NJ 07018

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Alcohol, Narcotic and Drug Abuse

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Trenton, NJ 08625-0362

(609) 292-8930

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NEW YORK

Bronx

Albert Einstein College of Medicine

Division of Substance Abuse

1500 Waters Place

Bronx, NY 10461

(212) 409-9450

Principal Investigator: Joyce Lowensin, M.D.

Assistant Director: Ira Marion

Project Coordinator: Patti Juliana, M.S.W.

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Training Coordinator: Kimberly Lewis

Brooklyn

ADAPT

Narcotic and Drug Research Institute (NDRI)

11 Beach Street

New York, NY 10013

(212) 966-8700

Principal Investigator: Samuel Friedman, Ph.D.

Project Director: Meryl Sufian

Training Coordinator: Robert DeLena (Acting)

Woodhall Medical Mental Health Center

Ambulatory Care

760 Broadway

Brooklyn, NY 11206

(718) 963-8351

Site Coordinators: Peter Laqueur; Ada Klein

Training Coordinator: Millie Braunstein, R.N., M.N.,

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Buffalo

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Nassau County Department of Drug and Alcohol Addiction

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New York

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Community AIDS Prevention Outreach Demonstration Project
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NORTH CAROLINA

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Center for Social Research and Policy Analysis

Research Triangle Institute

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OHIO**Cincinnati**

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Co-Principal Investigator: Ronn Rucker, Ed.D.,

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Cleveland

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Department of Sociology

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Co-Principal Investigator: Shadi Roman, Ph.D.,

(216) 881-0540

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(216) 881-0540

Cuyahoga County Drug Abuse Service Board

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Cleveland, OH 44115

(216) 881-0540

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Cleveland Treatment Center

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Cleveland, OH 44115

(216) 861-4242

Outreach Coordinator: Willie Pace

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Wright State University School of Medicine

Substance Abuse Intervention Programs

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1800 North James H. McGee Boulevard

Dayton, OH 45427

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OHIO (continued)

2122 North Main Street
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Project Coordinator - Dayton: Diana L. Alexander

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AIDS Activities Center
181 South Washington Boulevard
Columbus, OH 43215
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OREGON**Portland**

Multnomah County Health Division
HIV Outreach Project
20 NE 10th Street, 2nd Floor
Portland, OR 97232
(503) 248-3030

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PUERTO RICO**Rio Piedras**

Puerto Rico AIDS Prevention Project
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RHODE ISLAND

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TEXAS

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Training Coordinator: Bert Phillips

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WASHINGTON

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